

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

11467

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11461

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b 13-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 N.St. Johns Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 109 N. St. Johns Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES P. GRAY First Middle Last 4. DATE OF DEATH Aug. 21, 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 11, 1904 9. AGE (In years last birthday) 61 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P. Telephone Co. 11. BIRTHPLACE (State or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Resin D. Gray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 252-03-8514		17. INFORMANT Carl W. Kramer, Sykesville, Md Address Rt. 1 Box 114	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Instant 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Thomas F. Herbert M.D. EXAMINER'S NAME (Type) Thomas F. Herbert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 44 Church Rd. Ellicott City, Md Address (Street, city, town, or county) 22. DATE SIGNED 8/2/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8-24-1966 23c. NAME OF CEMETERY OR CREMATORY Lorraine 23d. LOCATION (City or Town) (County) (State) Baltimore, Md		24. FUNERAL DIRECTOR F.C. Higinbotham ADDRESS Ellicott City, Md. 25a. REC'D BY REGISTRAR DATE AUG 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

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VR A15ME (S)
6M 1/66

11468

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G380 9/6/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11464

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 No. Penfield Rd.				d. STREET ADDRESS 3 N. Penfield Road			
3. NAME OF DECEASED (Type or print) First MARION Middle H. Last KELLY				4. DATE OF DEATH Month 8 Day 30 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Toledo, Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Hill				14. MOTHER'S MAIDEN NAME Mary Sullivan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Robert W. Kelly, 3 N. Penfield Drive, E.C. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8/31/66	
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-1966		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City or Town) (County) (State) Elkridge, Md	
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md				25a. REC'D BY REGISTRAR DATE SEP 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11469

11463

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAVAGE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 MADISON ST</u>				d. STREET ADDRESS <u>300 Madison St</u>			
3. NAME OF DECEASED (Type or print) <u>Suzanne B. Kinzie</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-01</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ft. Meade</u>		11. BIRTHPLACE (State or foreign country) <u>NEW HARTFORD, Conn USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW BSULLAR</u>				14. MOTHER'S MAIDEN NAME <u>ANNA BRASEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>041-26-3660</u>		17. INFORMANT Address <u>Donald R. Kinzie, Savage, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mnt</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>444 Orchard Rd</u>				DATE SIGNED <u>8/25/66</u>			
Address (Street, city, town, or county) <u>Ellicott City, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/29/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>			
23. FUNERAL DIRECTOR <u>Dewitt Donaldson, 313 Talbot Ave, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 1 1966</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11470

CERTIFICATE OF DEATH

11464

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT. # 1 WATERLOO ROAD		d. STREET ADDRESS RT. # 1 WATERLOO ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		13-1	
3. NAME OF DECEASED (Type or print) First KATIE Middle NEIGHOFF Last NEIGHOFF		4. DATE OF DEATH Month AUGUST Day 7 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1885
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH BULLINGER		14. MOTHER'S MAIDEN NAME SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. WALTER NEIGHOFF, 3618 COOLIDGE AVENUE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 , to July 7, 1966 , that (I) (we) last saw the deceased alive on July 7, 1966 , and that death occurred at 7:00 M, from causes and on the date stated above.			
22a. SIGNATURE Frank E. Shipley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANK E. SHIPLEY		22d. ADDRESS 11 BALTIMORE STREET-SAVAGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-10-66	
23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		25a. REC'D BY REGISTRAR DATE AUG 11 1966	
25b. REGISTRAR'S SIGNATURE Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

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VR A15ME
SM 1/63

11471
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence of wife admission) a. STATE <u>md</u> b. COUNTY <u>Proctor Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 Jefferson St</u>				d. STREET ADDRESS <u>15 Jefferson St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Karl Jonathan SAMUELSON</u>				4. DATE OF DEATH Month Day Year <u>Aug. 21 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1887</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sweden</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nilson</u>				14. MOTHER'S MAIDEN NAME <u>Maria Samuelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>037-07-6460</u>		17. INFORMANT Address <u>E. Dorthick, 15 Jefferson St. Savage, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>							
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>							
DUE TO (c) <u>5yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Thomas L. Herbert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Thomas P. Herbert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8/21/66</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug 25, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	
23. FUNERAL DIRECTOR <u>F. Busch's Sons Hyattsville Md</u>				22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>		22e. (State) <u>Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 24 1966</u>				24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some words like "The", "and", "of", "in" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
11472					11466							
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge c. LENGTH OF STAY IN 1b 13-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1942 Furnace Ave					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge d. STREET ADDRESS 1942 Furnace Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES FRANCIS WEBER			4. DATE OF DEATH Aug. 28, 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH July 21, 1904			9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY			13. FATHER'S NAME Charles T. Weber			14. MOTHER'S MAIDEN NAME Alice Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-14-6556			17. INFORMANT Mrs. Emma M. Weber, 1942 Furnace Ave. Elkridge			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Cardio Vascular Disease 5 yrs DUE TO (b) General Arteriosclerosis DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH 5 yrs			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Aug 28, 1966 , that (I) (we) last saw the deceased alive on Aug 28, 1966 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
22a. SIGNATURE B. B. Drumbaugh			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) B. B. Drumbaugh		22d. ADDRESS Elkridge 27 Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 8-31-1966			23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City, town or county) (State) Elkridge, Md		24. FUNERAL DIRECTOR F. C. Higginbotham			25a. REC'D BY REGISTRAR AUG 31 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE			25e. REGISTRAR'S SIGNATURE			

F. C. Higginbotham, Elkridge City, Md.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To burial, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #12 Film #G380 9/19/66pc

Reg. Dist. No: 11467

11473

1. PLACE OF DEATH a. COUNTY HOWARD CO. ELLICOTT CITY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) # 5 GRACE CT.		d. STREET ADDRESS # 5 GRACE CT	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Wisniewski		4. DATE OF DEATH Month Day Year Aug 22 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? - U.S.A.	
13. FATHER'S NAME JOHN WISNIEWSKI		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address RECILIA GROZYK- 5 GRACE CT ELLICOTT SF.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 165X DUE TO Carcinoma, lungs 8 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour c. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Thomas F. Herbert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Thomas F. Herbert, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 44 Church Rd. 8/24/66	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ELLICOTT CITY MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-66	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		22d. LOCATION (City, town, or county) (State) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE JW Gajewski		24a. REC'D BY REGISTRAR DATE AUG 25 1966	
ADDRESS 1930 Eastern Ave		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

11401

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]